DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On June 19, 2008, an investigation (DC00001569) was initiated at Multi Therapeutic Services (MTS) to ascertain information regarding the frequency of serious incidents involving Client #1. According to the Department of Health's incident management system, the following incidents were reported: On April 25, 2008, staff reported that Client #1 fell while attempting to exit the shower. The client sustained a laceration to his scalp and was subsequently transported to the emergency room (via 911) for evaluation. Client #1 received sutures to his injury and was discharged that same day in stable condition. On May 13, 2008, staff reported that Client #1 appeared to be "very tired." The facility nurse took the client's blood pressure and noted that it was very low. Client #1 was subsequently transported to the emergency room (via 911). Client #1 was admitted to the hospital for abnormal labs and hypotension. On June 2, 2008, staff reported that Client #1 fell and sustained a scrape above his left eye. The client was transported to the emergency room for evaluation and was discharged that same day in stable condition. On June 5, 2008, staff reported that Client #1 fell and hit his chin on a stair while attempting to ascend a staircase in the facility. The client was escorted to the emergency room and was diagnosed with a gum laceration. While at the hospital, no x-rays were conducted. The client was given a prescription for antibiotics to be taken four times a day. On June 6, 2008, the facility's nursing personnel reported that Client #1's jaw was swollen. As a result of the observed swelling, Client #1 was	W 000		

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 AUG -4 P 4:04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott A. Moore (Director of Residential Services) TITLE (X6) DATE: 8/4/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 1 taken back to the emergency room for x-rays of the face and jaw. The report further documented that Client #1's Primary Care Physician (PCP) called and notified the group home that the client had a mandibular fracture. On June 9, 2008, the facility's incident management coordinator reported an allegation of abuse involving Client #1 on May 7, 2008. According to incident report, Client #1 revealed to a Department of Disability Services (DDS) investigator that a facility staff member "beats me up all the time." During the investigative process on June 30, 2008, at 4:28 PM, it was determined that Client #1's health and safety was compromised and an immediate jeopardy existed under the Condition of Participation of Client Protections. The facility's Qualified Mental Retardation Professional (QMRP) was notified via telephone of the immediate jeopardy and at approximately 8:40 PM systems were employed by the facility to alleviate the immediate concern prior to the surveyor exiting the facility. The findings of the investigation were based on observations, interviews and a review of records, including unusual incident reports. The results of the investigation revealed that the facility failed to maintain compliance with the Conditions of Participation of Governing Body, Client Protection, and Facility Staffing.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102 MTS has made the necessary corrections to insure that the governing body insures adequate client protections on a routine basis as outlined in the plan of correction submitted and the specific responses to each citation ... 8-4-08.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 102	Continued From page 2 This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility to ensure the maintenance of each client's health and safety [See W104 and W127]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure clients' were free from neglect. [See also W122]	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility's governing body failed to provide general operating directions over the facility as reflected in deficiencies cited throughout this report.	W 104	W104 The governing body will insure that the necessary direction is provided routinely as outlined in this plan of correction ... 8-4-08.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the health and safety of one client by making certain systems were developed/implemented to reduce the frequency of unusual incidents requiring emergency medical care (See W127).[	W 122	W122 See responses for W102 and W104 above. It should be noted that client #1 has a degenerative condition that will continue to negatively affect his gross motor function and create other health/safety concerns. MTS will monitor this deterioration and adjust his plan or care as needed to reflect his changing needs ... 8-30-08.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 122	Continued From page 3 The effects of these systemic practices resulted in the failure of the facility to protect Client #1 and ensure his health and safety.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the health and safety of one client by making certain systems were developed/implemented to reduce the frequency of unusual incidents requiring emergency medical care, for one of one client (Client #1) being investigated. The finding includes: A. Client #1 was admitted to the facility on June 12, 2008 due to a history of falls which resulted in injuries that lead to emergency room visits and a hospitalization. Interview was conducted with the facility ' s House Manager (HM) on June 19, 2008 at 10:35 AM that revealed three staff were transferred (Staff 1, Staff 2, and Staff 3) from the client's former facility to his current facility to assist in his transition and provide continuity in his care. The staff that were transferred were to provide one to one staffing support for Client #1. B. Further discussion with the HM on June 19,	W 127	W127 Client #1's one-to-one staff was trained on the PT protocols while supporting client #1 at 32 Street. This training was conducted by the QMRP. They were subsequently trained by the PT in two sessions held at Lee Street. MTS will insure that any new staff is trained on all treatment protocols prior to working with client #1 and that all new staff receives orientations on each individual health management care plan and all treatment protocols within the first week of service ... 8-20-08. The PT will monitor client #1 and the implementation of his treatment protocols at minimum quarterly and more frequently if needed ... 8-30-08. The QMRP will monitor implementation of the treatment protocols and active treatment generally at minimum twice weekly ... 8-20-08. PT will provide training for any new staff within 30 days of their hire and the RN will provide training within the first week of hire to insure that new staff is effective in implementing the treatment protocols. All staff will receive refresher training at minimum annually but more frequently if necessary based on observed performances. The QMRP will document staff training observations using standard MTS forms ... 8-20-08. All staff involved in observations mentioned in W127 by the surveyor has been re-trained by the PT and QMRP ... 8-4-08. It should be noted that client #1 has a serious degenerative condition that will cause his gross motor function to deteriorate further. MTS will monitor him diligently and adjust his treatment regimen to reflect new issues and concerns but will also cooperate with efforts to find a long term placement that will best serve his needs given his situation ... 8-4-08.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 4 2008, revealed that prior to Client #1's transition into the facility, the former QMRP held an inservice meeting with the facility's staff to orientate them with Client #1's habilitation/service needs. Review of the inservice sign in sheet and corresponding agenda document dated June 12, 2008, revealed four staff attended the inservice training. There was no evidence that two of Client #1's assigned one to one staff members (Staff 1 and Staff 3) were present at the training. Further review of the inservice agenda document revealed that staff were made aware of the following information regarding Client #1: - "Takes medication to reduce aggression." - "Wears glasses/refuses to wear them." - "1 on 1 should be with him arm to arm assisting." - "Has BSP to reduce Aggression." - "He had 4 recent injuries due to falling." Continued interview with the HM on June 19, 2008, revealed that during the aforementioned inservice, the former QMRP instructed staff to remain in arm's distance of Client #1 at all times. The HM further revealed that the facility was providing 1:1 staffing supports for Client #1 (within arm's distance) 24 hours a day, 7 days a week. Interview was conducted with the facility's Qualified Mental Retardation Professional (QMRP) on June 19, 2008 at approximately 4:00 PM to ascertain if staff had received any other training specifically related to Client #1 since he moved into the facility. The QMRP replied and indicated that no other training had been conducted and further revealed that formal	W 127	The team meeting mentioned was held with these agreed upon recommendations: • Seek a more appropriate placement that will better meet client #1's needs long term. • In the interim, provide one-to-one supports 24/7 via trained staff. • Consistently implement the treatment support protocols as prescribed. • Rule out the use of a walker as this has been tried twice unsuccessfully. He will not use one. • Use a wheelchair for entering and leaving the van and for community travel. • Support client #1 in entering and leaving the facility by insuring that he uses the hand rail and has one-to-one staff support on the other side. • PT monitoring at minimum quarterly to assess degenerative situation with gross motor function. • Staff training as needed to insure routine and appropriate implementation of the treatment protocols. • QMRP and RN monitoring of staff support to insure proper implementation of support protocols. • Staff report signs and symptoms of illness, pain, distress or decline in function to RN and/or PCP. • Coordinate with day program, share all information and protocols (day program attended team meeting). • Provide staff support for transfers, standing and short distance walking as per the protocols. • Complete the nerve conduction velocity test as recommended by the PT if the PCP concurs (scheduled via a physiatrist for 8-14-08)...8-14-08. • Keep home and walkways obstruction-free. • Monitor for falls, maintain staff proximity to prevent falls.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 5 training with the facility's Physical Therapist (PT) and Psychologist were scheduled to be held the following week. At the time of the interview and since the client's admission into the facility on June 12, 2008, the facility failed to provide evidence of any other training related to Client #1's habilitation needs and services other than the aforementioned training conducted by the former QMRP. It should be noted that after the QMRP's discussion with the surveyor on June 19, 2008, the facility's PT was observed to be in the facility. The PT provided onsite instruction to four of the facility's staff, including Staff 1 and Staff 2 regarding Client #1's formal PT program, techniques for transfers, and providing assistance during ambulation. Additionally, interview with the PT revealed that staff should remain next to the client at all times. On June 27, 2008 an onsite visit was conducted at Client #1's residence. At approximately 10:53 AM on June 27, 2008, the QMRP notified the surveyor that Client #1 fell while on a medical appointment and was subsequently transferred to the emergency room for evaluation. Review of the corresponding emergency department discharge summary on June 30, 2008 revealed the client was diagnosed with a scalp contusion. Interview with Staff 1 on June 30, 2008, revealed the events that led to Client #1's incident on June 27, 2008. Staff 1 revealed that while seated beside Client #1 at the doctor's office, he attempted to stand up after his name was called to be seen for his medical appointment. Client #1 stood and fell forward, hitting his face on the floor. Staff 1 explained that during the process of the fall, he/she held onto Client #1 by his belt and waist.	W 127		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 6 C. Observation of Staff 1 on June 30, 2008, at 10:25 AM, revealed Staff 1 seated on the chair in the living room (closest to front door) approximately 3 feet away from where Client #1 was seated. When queried about his/her distance from the client, Staff 1 revealed that he/she was supposed to be seated beside the client. Staff 1 further revealed that his/her position/distance from Client #1 at the time of the observation was wrong. On June 30, 2008 at 11:32 AM Staff 1 was observed to be positioned on the right side of Client #1 while the client was ambulating. As the client approached the entrance of the facility (to exit), Staff 1 was observed to have his/her left arm extended and around Client #1's waist. Additional observation of Client #1 was conducted on June 30, 2008 at 3:21 PM. At the time of the observation, Client #1 was being assisted by Staff 2. Staff 2 was observed to leave Client #1 alone (only surveyor present), seated on a chair in the living room, while he/she retrieved the client's wheelchair. Staff 2 left the living room, went through the dining room, through the kitchen and out of sight of the surveyor and Client #1. Review of Client #1's record on June 19, 2008 revealed an "Ambulation Protocol" dated May 2, 2008 designed by the current PT and to be implemented by the current facility. The protocol documented the following: Allow [Client #1] to transfer and ambulate. Guard him on either side. Your body should be close to his body without interfering with his movements. Do not try and guard [Client #1] with outstretched	W 127		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 7 arms. Avoid holding [Client #1] on his arm. If he starts to lose his balance, use your arms and position your body against his body to assist with regaining his balance. Avoid pulling on his upper extremities. It should be noted, that interview with the current HM and QMRP and record review failed to provide evidence that any staff were inserviced on the aforementioned protocol prior to the PT training at Client #1's current facility on June 23, 2008. At that training, staff were instructed on fall prevention, providing assistance during ambulation, safety and documentation for Client #1 The QMRP was notified on June 30, 2008, at 4:28 PM (via telephone) of the State Agency's determination that the facility failed to ensure staff were knowledgeable regarding Client #1's needed supervision and furthermore failed to make certain that staff provided the required support to prevent incidents of falling. This failure resulted in neglect which posed a serious and immediate threat to Client #1's health and safety. The surveyor remained onsite until the facility addressed the serious and immediate jeopardy by initiating a plan that prohibited the morning (7AM-3PM)one to one staff (Staff 1) and the evening (3PM-11PM) one to one staff (Staff 2) from assisting Client #1. The facility's Registered Nurse provide training to the facility staff that were on duty (June 30, 2008) on "What you can do to prevent falls." The QMRP further instituted a schedule that incorporated the use of one to one staff that were trained to effectively provide Client #1 with the required staffing support and	W 127		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 8 supervision. Additionally, the plan documented that the Physical Therapist would provide further training to all staff on Client #1's ambulation protocol. A system of monitoring was also implemented to ensure staff were providing the supervision appropriately. Furthermore, the QMRP revealed that a meeting would be held with Client #1's interdisciplinary team regarding his status. At approximately 8:40 PM, systems were employed by the facility to alleviate the immediate concern.	W 127		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; failed to ensure each employee was provided with initial and continued training that enabled them to perform their duties effectively, efficiently, and competently [See W189]; and failed to ensure employees were effectively trained to provide for each client's health and safety [See W127 and W192]. The effects of these systemic practices results in the facility's failure to provide adequate staffing and ensure his health and safety. [See also W122]	W 158	W158 MTS has insured systemic corrections were put in place to address staff training issues immediately and moving forward... 8-4-08. See also the responses for W127.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 9 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: The QMRP failed to to ensure employees were effectively trained to provide Client #1 with 1:1 staffing supports. (See W192)	W 159	W159 See the attached documentation. One-to-One staff has been trained ... 8-4-08. The QMRP will insure that any new one-to-one staff support person is trained on all treatment protocols for the targeted person supported before beginning to work one-to-one with that person ... 8-20-08.	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure employees were effectively trained to provide for each client's health and safety, for one of one client (Client #1) being investigated. The finding includes: A. (Cross refer to W127) On June 27, 2008 an onsite visit was conducted at Client #1's residence. At approximately 10:53 AM on June 27, 2008, the QMRP notified the surveyor that Client #1 fell while on a medical appointment and was subsequently transferred to the emergency room for evaluation. Review of the corresponding	W 192	W192 The staff members cited in W192 have been re-trained by the PT ... 8-4-08. In addition, the QMRP and RN will monitor routine implementation of the protocols to insure proper implementation (RN weekly, QMRP twice weekly) ... 8-4-08.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 10 emergency department discharge summary on June 30, 2008 revealed the client was diagnosed with a scalp contusion. Interview was conducted on June 27, 2008, beginning at 10:39 AM, with the staff member (Staff 1) present on the medical appointment with Client #1 on June 30, 2008. Staff 1 revealed that while seated beside Client #1 at the doctor's office, he attempted to stand up after his name was called to be seen for his medical appointment. Client #1 stood and fell forward, hitting his face on the floor. Staff 1 explained that during the process of the fall, he/she held onto Client #1 by his belt and waist. B. Observation of Staff 1 on June 30, 2008, at 10:25 AM, revealed Staff 1 seated on the chair in the living room (closest to front door) approximately 3 feet away from where Client #1 was seated. When queried about his/her distance from the client, Staff 1 revealed that he/she was supposed to be seated beside the client. Staff 1 further revealed that his/her position/distance from Client #1 at the time of the observation was wrong. On June 30, 2008 at 11:32 AM Staff 1 was observed to be positioned on the right side of Client #1 while the client was ambulating. As the client approached the entrance of the facility (to exit), Staff 1 was observed to have his/her left arm extended and around Client #1's waist. Additional observation of Client #1 was conducted on June 30, 2008 at 3:21 PM. At the time of the observation, Client #1 was being assisted by Staff 2. Staff 2 was observed to leave Client #1 alone (only surveyor present), seated on a chair in the	W 192		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 11 living room, while he/she retrieved the client's wheelchair. Staff 2 left the living room, went through the dining room, through the kitchen and out of sight of the surveyor and Client #1. Note: Review of Client #1's record on June 19, 2008 revealed an "Ambulation Protocol" dated May 2, 2008. This protocol was designed by the facility ' s PT, who also provided training to the staff on June 19. 2008 and June 23, 2008. The protocol documented the following: Allow [Client #1] to transfer and ambulate. Guard him on either side. Your body should be close to his body without interfering with his movements. Do not try and guard [Client #1] with outstretched arms. Avoid holding [Client #1] on his arm. If he starts to lose his balance, use your arms and position your body against his body to assist with regaining his balance. Avoid pulling on his upper extremities. Four inservice trainings were held related to Client #1 as detailed below: June 12, 2008 - Inservice training that relayed general information about Client #1 (conducted by the former Qualified Mental Retardation Professional). Review of the inservice sign in sheet and corresponding agenda document dated June 12, 2008, revealed four staff attended the inservice training. There was no evidence that two of Client #1's assigned one to one staff members (Staff 1 and Staff 3) were present at the training. Interview with Client #1's current House Manager (HM) on June 19, 2008 beginning at 10:35 AM revealed that during the	W 192		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 12 aforementioned inservice, the former QMRP instructed staff to remain in arm's distance of Client #1 at all times. The HM further revealed that the facility was providing 1:1 staffing supports for Client #1 (within arm's distance) 24 hours a day, 7 days a week. June 19, 2008 - Inservice training provided to four staff, including Staff 1 and Staff 2, regarding Client #1's formal Physical Therapy (PT) program, techniques for transfers, and providing assistance during ambulation (conducted by the PT). Additionally, interview with the PT revealed that staff should remain next to the client at all times. June 23, 2008 - Inservice training regarding Client #1 provided to staff that on fall prevention, providing assistance during ambulation, safety and documentation (conducted by the PT). June 24, 2008 - Inservice regarding Client #1's behavioral concerns (conducted by the Psychologist). At the time of the survey, the facility failed to ensure staff proficiently displayed their knowledge of Client #1's required 1:1 staffing support.	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS On June 18, 2008, an investigation (DC00001569) was initiated at Multi Therapeutic Services (MTS) to ascertain information regarding the frequency of serious incidents involving Resident #1. The investigation findings were based on observations, interviews, and a review of records, including unusual incident reports.	I 000		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure employees were effectively trained to provide for each client's health and safety, for one of one residents (Resident #1) being investigated. The finding includes: A. (Cross refer to Federal Deficiency Report Citation W127) On June 27, 2008 an onsite visit was conducted at Client #1's residence. At approximately 10:53 AM on June 27, 2008, the QMRP notified the surveyor that Client #1 fell while on a medical appointment and was subsequently transferred to the emergency room for evaluation. Review of the corresponding emergency department discharge summary on June 30, 2008 revealed the client was diagnosed	I 229	W127 Client #1's one-to-one staff was trained on the PT protocols while supporting client #1 at 32 Street. This training was conducted by the QMRP. They were subsequently trained by the PT in two sessions held at Lee Street. MTS will insure that any new staff is trained on all treatment protocols prior to working with client #1 and that all new staff receives orientations on each individual health management care plan and all treatment protocols within the first week of service ... 8-20-08. The PT will monitor client #1 and the implementation of his treatment protocols at minimum quarterly and more frequently if needed ... 8-30-08. The QMRP will monitor implementation of the treatment protocols and active treatment generally at minimum twice weekly ... 8-20-08. PT will provide training for any new staff within 30 days of their hire and the RN will provide training within the first week of hire to insure that new staff is effective in implementing the treatment protocols. All staff will receive refresher training at minimum annually but more frequently if necessary based on observed performances. The QMRP will document staff training observations using standard MTS forms ... 8-20-08. All staff involved in observations mentioned in W127 by the surveyor has been re-trained by the PT and QMRP ... 8-4-08. It should be noted that client #1 has a serious degenerative condition that will cause his gross motor function to deteriorate further. MTS will monitor him diligently and adjust his treatment regimen to reflect new issues and concerns but will also cooperate with efforts to find a long term placement that will best serve his needs given his situation ... 8-4-08.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 1 with a scalp contusion. Interview was conducted on June 27, 2008, beginning at 10:39 AM, with the staff member (Staff 1) present on the medical appointment with Client #1 on June 30, 2008. Staff 1 revealed that while seated beside Client #1 at the doctor's office, he attempted to stand up after his name was called to be seen for his medical appointment. Client #1 stood and fell forward, hitting his face on the floor. Staff 1 explained that during the process of the fall, he/she held onto Client #1 by his belt and waist. B. Observation of Staff 1 on June 30, 2008, at 10:25 AM, revealed Staff 1 seated on the chair in the living room (closest to front door) approximately 3 feet away from where Client #1 was seated. When queried about his/her distance from the client, Staff 1 revealed that he/she was supposed to be seated beside the client. Staff 1 further revealed that his/her position/distance from Client #1 at the time of the observation was wrong. On June 30, 2008 at 11:32 AM Staff 1 was observed to be positioned on the right side of Client #1 while the client was ambulating. As the client approached the entrance of the facility (to exit), Staff 1 was observed to have his/her left arm extended and around Client #1's waist. Additional observation of Client #1 was conducted on June 30, 2008 at 3:21 PM. At the time of the observation, Client #1 was being assisted by Staff 2. Staff 2 was observed to leave Client #1 alone (only surveyor present), seated on a chair in the living room, while he/she retrieved the client's wheelchair. Staff 2 left the living room, went through the dining room, through the kitchen and out of sight of the	I 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 2 surveyor and Client #1. Note: Review of Client #1's record on June 19, 2008 revealed an "Ambulation Protocol" dated May 2, 2008. This protocol was designed by the facility ' s PT, who also provided training to the staff on June 19. 2008 and June 23, 2008. The protocol documented the following: Allow [Client #1] to transfer and ambulate. Guard him on either side. Your body should be close to his body without interfering with his movements. Do not try and guard [Client #1] with outstretched arms. Avoid holding [Client #1] on his arm. If he starts to lose his balance, use your arms and position your body against his body to assist with regaining his balance. Avoid pulling on his upper extremities. Four inservice trainings were held related to Client #1 as detailed below: June 12, 2008 - Inservice training that relayed general information about Client #1 (conducted by the former Qualified Mental Retardation Professional). Review of the inservice sign in sheet and corresponding agenda document dated June 12, 2008, revealed four staff attended the inservice training. There was no evidence that two of Client #1's assigned one to one staff members (Staff 1 and Staff 3) were present at the training. Interview with Client #1's current House Manager (HM) on June 19, 2008 beginning at 10:35 AM revealed that during the aforementioned inservice, the former QMRP instructed staff to remain in arm's distance of Client #1 at all times. The HM further revealed that the facility was providing 1:1 staffing supports	I 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 3 for Client #1 (within arm's distance) 24 hours a day, 7 days a week. June 19, 2008 - Inservice training provided to four staff, including Staff 1 and Staff 2, regarding Client #1's formal Physical Therapy (PT) program, techniques for transfers, and providing assistance during ambulation (conducted by the PT). Additionally, interview with the PT revealed that staff should remain next to the client at all times. June 23, 2008 - Inservice training regarding Client #1 provided to staff that on fall prevention, providing assistance during ambulation, safety and documentation (conducted by the PT). June 24, 2008 - Inservice regarding Client #1's behavioral concerns (conducted by the Psychologist). At the time of the survey, the facility failed to ensure staff proficiently displayed their knowledge of Client #1's required 1:1 staffing support.	I 229		
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of all Staff 2's personnel record.	I 271	3513.1(b) Criminal background checks for all staff are attached... 8-4-08. At present all staff hired is checked using the national registry... 8-4-08. MTS has gone back to do the national registry check on individuals who did not have it in the past. That is why there are June 2008 checks for some individuals who were done via the jurisdictional check previously.	

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 271	Continued From page 4 The finding includes: Interview with Resident #1's former House Manager (HM) and former Qualified Mental Retardation Professional (on June 18, 2008 and June 19, 2008 respectively) and review of personnel records on June 18, 2008 and June 19, 2008, revealed that the facility failed to provide evidence that a criminal background check was conducted on Staff 2 prior to his/her employment. It should be further noted that on June 27, 2008, while conduct an on-site visit, a second request was made to the former HM for Staff 2's personnel file. At the time of the investigation, the facility failed to provide evidence of Staff 2's personnel file to include his/her criminal background check.	I 271		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's rights were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws. The findings include: A. The GHMRP failed to ensure each resident's rights as documented in D.C. Law 2-137, Chapter 19 , § 6-1970 detailing the prohibition of mistreatment, neglect or abuse.	I 500	3523.1 All staff has been trained on the PT protocols for client #1. See the attached training documentation. See also, the responses for W127...8-4-08. The corrections observed by the surveyor and mentioned in the report that were implemented by the QMRP will continue to be implemented on a routine ongoing basis and will be monitored by the Executive Director and Assistant to insure this...8-20-08.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 5 Client #1 was admitted to the facility on June 12, 2008 due to a history of falls which resulted in injuries that lead to emergency room visits and a hospitalization. Interview was conducted with the facility ' s House Manager (HM) on June 19, 2008 at 10:35 AM that revealed three staff were transferred (Staff 1, Staff 2, and Staff 3) from the client's former facility to his current facility to assist in his transition and provide continuity in his care. The staff that were transferred were to provide one to one staffing support for Client #1. B. Further discussion with the HM on June 19, 2008, revealed that prior to Client #1's transition into the facility, the former QMRP held an inservice meeting with the facility's staff to orientate them with Client #1's habilitation/service needs. Review of the inservice sign in sheet and corresponding agenda document dated June 12, 2008, revealed four staff attended the inservice training. There was no evidence that two of Client #1's assigned one to one staff members (Staff 1 and Staff 3) were present at the training. Further review of the inservice agenda document revealed that staff were made aware of the following information regarding Client #1: - "Takes medication to reduce aggression." - "Wears glasses/refuses to wear them." - "1 on 1 should be with him arm to arm assisting." - "Has BSP to reduce Aggression." - "He had 4 recent injuries due to falling." Continued interview with the HM on June 19, 2008, revealed that during the aforementioned	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 6 inservice, the former QMRP instructed staff to remain in arm's distance of Client #1 at all times. The HM further revealed that the facility was providing 1:1 staffing supports for Client #1 (within arm's distance) 24 hours a day, 7 days a week. Interview was conducted with the facility ' s Qualified Mental Retardation Professional (QMRP) on June 19, 2008 at approximately 4:00 PM to ascertain if staff had received any other training specifically related to Client #1 since he moved into the facility. The QMRP replied and indicated that no other training had been conducted and further revealed that formal training with the facility's Physical Therapist (PT) and Psychologist were scheduled to be held the following week. At the time of the interview and since the client's admission into the facility on June 12, 2008, the facility failed to provide evidence of any other training related to Client #1's habilitation needs and services other than the aforementioned training conducted by the former QMRP. It should be noted that after the QMRP's discussion with the surveyor on June 19, 2008, the facility's PT was observed to be in the facility. The PT provided onsite instruction to four of the facility's staff, including Staff 1 and Staff 2 regarding Client #1's formal PT program, techniques for transfers, and providing assistance during ambulation. Additionally, interview with the PT revealed that staff should remain next to the client at all times. On June 27, 2008 an onsite visit was conducted at Client #1's residence. At approximately 10:53 AM on June 27, 2008, the QMRP notified the surveyor that Client #1 fell while on a medical appointment and was subsequently transferred to the emergency room for evaluation. Review of	I 500		

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 7 the corresponding emergency department discharge summary on June 30, 2008 revealed the client was diagnosed with a scalp contusion. Interview with Staff 1 on June 30, 2008, revealed the events that led to Client #1's incident on June 27, 2008. Staff 1 revealed that while seated beside Client #1 at the doctor's office, he attempted to stand up after his name was called to be seen for his medical appointment. Client #1 stood and fell forward, hitting his face on the floor. Staff 1 explained that during the process of the fall, he/she held onto Client #1 by his belt and waist. C. Observation of Staff 1 on June 30, 2008, at 10:25 AM, revealed Staff 1 seated on the chair in the living room (closest to front door) approximately 3 feet away from where Client #1 was seated. When queried about his/her distance from the client, Staff 1 revealed that he/she was supposed to be seated beside the client. Staff 1 further revealed that his/her position/distance from Client #1 at the time of the observation was wrong. On June 30, 2008 at 11:32 AM Staff 1 was observed to be positioned on the right side of Client #1 while the client was ambulating. As the client approached the entrance of the facility (to exit), Staff 1 was observed to have his/her left arm extended and around Client #1's waist. Additional observation of Client #1 was conducted on June 30, 2008 at 3:21 PM. At the time of the observation, Client #1 was being assisted by Staff 2. Staff 2 was observed to leave Client #1 alone (only surveyor present), seated on a chair in the living room, while he/she retrieved the client's wheelchair. Staff 2 left the living room, went through the dining room,	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 8 through the kitchen and out of sight of the surveyor and Client #1. Review of Client #1's record on June 19, 2008 revealed an "Ambulation Protocol" dated May 2, 2008 designed by the current PT and to be implemented by the current facility. The protocol documented the following: Allow [Client #1] to transfer and ambulate. Guard him on either side. Your body should be close to his body without interfering with his movements. Do not try and guard [Client #1] with outstretched arms. Avoid holding [Client #1] on his arm. If he starts to lose his balance, use your arms and position your body against his body to assist with regaining his balance. Avoid pulling on his upper extremities. It should be noted, that interview with the current HM and QMRP and record review failed to provide evidence that any staff were inserviced on the aforementioned protocol prior to the PT training at Client #1's current facility on June 23, 2008. At that training, staff were instructed on fall prevention, providing assistance during ambulation, safety and documentation for Client #1 The QMRP was notified on June 30, 2008, at 4:28 PM (via telephone) of the State Agency's determination that the facility failed to ensure staff were knowledgeable regarding Client #1's needed supervision and furthermore failed to make certain that staff provided the required support to prevent incidents of falling. This failure resulted in neglect which posed a serious and immediate threat to Client #1's health and safety.	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 9 The surveyor remained onsite until the facility addressed the serious and immediate jeopardy by initiating a plan that prohibited the morning (7AM-3PM)one to one staff (Staff 1) and the evening (3PM-11PM) one to one staff (Staff 2) from assisting Client #1. The facility's Registered Nurse provide training to the facility staff that were on duty (June 30, 2008) on "What you can do to prevent falls." The QMRP further instituted a schedule that incorporated the use of one to one staff that were trained to effectively provide Client #1 with the required staffing support and supervision. Additionally, the plan documented that the Physical Therapist would provide further training to all staff on Client #1's ambulation protocol. A system of monitoring was also implemented to ensure staff were providing the supervision appropriately. Furthermore, the QMRP revealed that a meeting would be held with Client #1's interdisciplinary team regarding his status. At approximately 8:40 PM, systems were employed by the facility to alleviate the immediate concern.	I 500		

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS On June 18, 2008, an investigation (DC00001569) was initiated at Multi Therapeutic Services (MTS) to ascertain information regarding the frequency of serious incidents involving Resident #1. The investigation findings were based on observations, interviews, and a review of records, including unusual incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and the review of records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person. The finding includes: A. Interview with Client #1's former House Manager (HM) and former Qualified Mental Retardation Professional (on June 18, 2008 and June 19, 2008 respectively) and review of personnel records on June 18, 2008 revealed that the facility failed to provide evidence that a criminal background check was conducted on Staff 2 prior to his/her employment. It should be further noted that on June 27, 2008, a second request was made to the former HM for Staff 2's personnel file. At the time of the investigation, the facility failed to provide evidence of Staff 2's	R 122	R122 and R125 Criminal background checks for each staff member of Lee are attached. MTS maintains criminal background checks in the home office but will produce them for review within 24 hours of the initiation of a survey hereafter... 8-4-08. As mentioned, MTS conducts the national registry search for all new staff at this point and is re-checking older staff via the national registry... 8-30-08.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 122	Continued From page 1 personnel file to include his/her criminal background check. B. Review of the personnel record for Staff 3 and interview with Client #1 former HM on June 18, 2008, revealed a criminal background check that disclosed a 7 year criminal history in all jurisdictions within which Staff 3 worked and resided was not on file. The former HM was interviewed to ascertain if all the necessary checks were conducted. On June 23, 2008, the required background check was provided for Staff 3. It should be noted however, that the background check was dated June 20, 2008 (after the staff's date of hire). [See also 4701.5]	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: 1. (Cross Refer to 4701.2) Interview with Client #1's former House Manager (HM) and former	R 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0232	A. BUILDING _____ B. WING _____	C 06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 2 Qualified Mental Retardation Professional (on June 18, 2008 and June 19, 2008 respectively) and review of personnel records on June 18, 2008 and June 19, 2008, revealed that the facility failed to provide evidence that a criminal background check was conducted and disclosed the required information for Staff 2 prior to his/her employment. 2. Interview with Client #1's former House Manager (HM) and former Qualified Mental Retardation Professional (on June 18, 2008 and June 19, 2008 respectively) and review of personnel records on June 18, 2008 and June 19, 2008 revealed Staff 1 had a criminal background check for the District of Columbia. It should be noted however, that there was no information provided in Staff 1's record that disclosed information regarding his/her residence or work history for the specified timeframe (7 years) prior to the staff's employment. At the time of the investigation, the facility's compliance with the aforementioned regulation could not be determined. Note: On June 27, 2008, while conducting an on-site visit, a second request was made to the former HM for Staff 1's missing information and Staff 2's personnel file.	R 125		